Complete Summary

GUIDELINE TITLE

Palliative sedation.

BIBLIOGRAPHIC SOURCE(S)

Editorial Board Palliative Care: Practice Guidelines. Palliative sedation. Utrecht, The Netherlands: Association of Comprehensive Cancer Centres (ACCC); 2006 Aug 1. 33 p. [66 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Diseases or conditions requiring palliative sedation (including terminal sedation) in the last stages of life, including but not limited to:

- Cancer
- Heart failure
- Chronic obstructive pulmonary disease (COPD)
- Amyotrophic lateral sclerosis (ALS)

GUIDELINE CATEGORY

Evaluation
Management

CLINICAL SPECIALTY

Cardiology
Family Practice
Internal Medicine
Neurology
Nursing
Oncology
Pharmacology
Psychology
Pulmonary Medicine

INTENDED USERS

Allied Health Personnel
Nurses
Pharmacists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

To improve the quality of palliative care for the individual patient by providing recommendations regarding diagnosis and treatment. Secondarily, this guideline may be used:

- To aid during consultations regarding palliative care
- To increase knowledge regarding palliative care
- To assist training and continuing education

TARGET POPULATION

Patients with incurable life-threatening disorders

INTERVENTIONS AND PRACTICES CONSIDERED

1. Decision making process (physician evaluation, patient and family wishes)
2. Documentation of decision process, sedation, and outcome
3. Supportive care for patient, family, and carers
4. Pharmacological interventions: sedative choice and sequence (midazolam, levomepromazine, phenobarbital, propofol, diazepam, lorazepam, clonazepam), dose and route of administration (continuous intravenous, subcutaneous, rectal, sublingual)
5. Ongoing patient observation and evaluation

MAJOR OUTCOMES CONSIDERED

- Degree of sedation and effectiveness in managing symptoms
- Patient and/or family satisfaction with care

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Studies in the palliative phase are methodologically difficult to conduct, placebo-controlled studies are often unfeasible, it is often practically and ethically difficult to accrue a sufficient number of patients, the follow-up period is short, and there are not always adequate financial resources to conduct trials in the palliative care setting. One is then left to collect the evidence available from case reports and case series.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

Level 1 = Based on a systematic review or at least two randomised trials of sufficient quality

Level 2 = Based on at least two comparative clinical trials of moderate quality or insufficient size, or other comparative studies

Level 3 = Based on one comparative trial or a non-comparative trial

Level 4 = Based on expert opinion

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

For each treatment recommendation found in the stepwise plan, the level of evidence upon which it was based and relevant references are provided. The level of evidence was determined using a classification system that conforms to that of the Centraal Begeleidings Orgaan (CBO).

The levels of evidence reflect the opinions of the authors and are open to discussion.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

No pretence was made to create evidence-based guidelines in the same sense that the Centraal Begeleidings Orgaan (CBO) guidelines are evidence-based. The methods required to develop evidence-based guidelines made the approach unfeasible given the time and financial restrictions placed on the editorial staff.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Not stated

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not applicable

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

No systematic research has been performed with regard to the effect of palliative sedation. All recommendations are based on Level IV (case reports or expert opinion) evidence.

Stepwise Approach

Decision-Making

1. Discuss as early as possible the wishes of the patient with regard to palliative sedation and give information about possibilities and restrictions.
2. If palliative sedation is considered, check whether indications and conditions are met:
    - The presence of one or more refractory symptoms

- Expertise and consensus of the team; if deemed necessary, consultation of an expert (e.g., a palliative care team)
- Sedation in line with the wish of the patient and/or his family
- In case of deep sedation: life expectancy <1 to 2 weeks

3. Document the process of decision-making in the medical file and inform all caregivers involved.

Procedure

1. Make decisions about the desired level (superficial or deep) and duration (temporary or permanent) of sedation and about evaluation of its effect; document this clearly in the medical file and inform all caregivers involved.
2. Ensure availability and attainableness of all professional caregivers and explain to the family how to contact them.
3. Consult, if necessary, a palliative care team for the administration of sedatives.
4. Generally, subcutaneous or intravenous administration of sedatives is preferred, using the following schedule:
    - Step 1: Midazolam 5 to 10 mg bolus, followed by 0.5 to 2.5 mg/hr; double the dose every 1 to 2 hours if effect insufficient; at dosages >20 mg/hr go to step 2.
    - Step 2: Levomepromazine 25 to 50 mg bolus, followed by 0.5 to 8 mg/hr in combination with midazolam; if midazolam and levomepromazine have insufficient effect, stop both drugs and go to step 3.
    - Step 3: Phenobarbital 100 to 200 mg bolus, followed by 40 mg/hr s.c./i.v., if necessary increased to 60 mg/hr after 24 hours; if phenobarbital has insufficient effect, stop phenobarbital and go to step 4.
    - Step 4: Propofol 20 mg/hr i.v., if necessary increased every 15 minutes by 10 mg/hr; administration under supervision of an anaesthesiologist advisable; may also be considered for step 2 in hospital setting.
5. In case of a short estimated life expectancy (<24 to 48 hours):
    - Midazolam 6dd 5 to 10 mg; if necessary double the dose every 4 hours
    - Diazepam 10 mg rectally every hour until adequate sedation is attained
    - Lorazepam sublingually 1 to 4 mg every 4 hours
    - Clonazepam sublingually 1 to 2.5 mg every 6 hours
6. Stop all unnecessary medication; continue morphine only to treat pain and/or dyspnoea and adjust the dose to the (presumed) degree of pain or dyspnoea.
7. Take additional measures if necessary (urinary catheter, prevention of bed sores, mouth care, enema).
8. Discontinue nutrition and/or fluids in case of permanent deep sedation; consider superficial or temporary sedation if discontinuing or not starting fluids is unwanted.
9. Evaluate the effect every 1 to 2 hours until an adequate and stable effect has been achieved and at least every 24 afterwards; titrate the dose to the level of (dis)comfort of the patient (proportionality). Readjust the dose of sedatives if necessary.
10. Document the course of sedation in the medical file.
11. Give support to the family and the caregivers involved.

CLINICAL ALGORITHM(S)

The original guideline document contains a clinical algorithm to decide whether a symptom is refractory.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

All recommendations are based on Level IV (case reports or expert opinion) evidence.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Relief of suffering and symptoms
- Improved quality of life

POTENTIAL HARMS

- Loss of the possibility to communicate
- Loss of the possibility to take fluids and risk of dehydration
- Medicalisation of the dying process
- Patients may respond to the initiation of sedation by becoming delirious (a rare complication, especially in children and elderly patients)

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The palliative phase is defined here as the period beginning the moment that cure is no longer possible for a patient with a life-threatening or potentially life-threatening disorder. For cancer, the transition to the palliative phase is usually clear, but for other disorders, such as heart failure or chronic obstructive pulmonary disease (COPD), the distinction between the curative and palliative phase is often vague. For disorders such as amyotrophic lateral sclerosis (ALS) that have no possible cure and ultimately and irrevocably lead to death, the palliative phase begins at diagnosis. The duration of the palliative phase can vary from weeks to years; therefore, the guideline is in no way limited to the terminal phase.
- The applicability and relevance of the diagnostic and treatment options discussed in these guidelines are highly dependent on the phase of the disease process and life expectancy.
- Care providers who make use of this guideline must determine which of the diagnostic and treatment options mentioned in the guideline are applicable to his or her working environment, specialty, and the individual situation of the patient in question.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Clinical Algorithm
Foreign Language Translations
Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

The first version of the Guideline on Palliative Sedation was written in 2001 as part of the guidelines on palliative care of the Comprehensive Cancer Center Middle-Netherlands.

DATE RELEASED

2006 Aug

GUIDELINE DEVELOPER(S)

Association of Comprehensive Cancer Centres - Disease Specific Society

SOURCE(S) OF FUNDING

Association of Comprehensive Cancer Centres

GUIDELINE COMMITTEE

Editorial Board Palliative Care: Practice Guidelines

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in English and Dutch from the Association of Comprehensive Cancer Centres Web site.

Print copies: Available from the Association of Comprehensive Cancer Centres PO Box 19001, 3501 DA Utrecht, The Netherlands

AVAILABILITY OF COMPANION DOCUMENTS

A version of the guideline for Personal Digital Assistants (PDAs) is also available at the Association of Comprehensive Cancer Centres Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on May 8, 2008. The information was verified by the guideline developer on July 15, 2008.

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